

Montana Department of Public Health & Human Services
SUBSTANCE ABUSE MANAGEMENT SYSTEM
CLIENT INSURANCE INFORMATION FORM

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Name:					Account #:				
Program #					Facility				
Account Opened Date (mmddyyyy)									
Company:									
Group Name:									
Group Number:									
Member Number:									
Begin Date (mmddyyyy)									
End Date (mmddyyyy)									
Status <input type="checkbox"/> Active <input type="checkbox"/> Cancelled									
Comments:									